Management of the schizophrenic patient

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Schizophrenia is a continuing and relapsing disorder that begins in early adulthood and lasts indefinitely. Effective treatment, therefore, needs to be long-term and comprehensive. The physician must be able to control disabling symptoms while minimizing the side effects of neuroleptic medication. The lifetime risk remains of depression and suicide, paranoid crisis, social distress and frequent rehospitalization. It is a medical responsibility not only to look after the schizophrenic patient's health but also to coordinate social and emergency services, improve the quality of life, support the family and anticipate problems in offspring. At the same time, the physician needs to consider the welfare of the community in which the schizophrenic patient lives.

La schizophrénie est une maladie continue et récurrente qui débute chez le jeune adulte et dure indéfiniment. Un traitement efficace doit donc être complet et de longue durée. Le médecin doit être capable de contrôler les symptômes invalidants tout en minimisant les effets secondaires des neuroleptiques. Le risque de dépression avec suicide, de crise paranoïaque, de misère sociale et d'hospitalisations fréquentes demeure constant toute la vie durant. C'est une responsabilité médicale de non seulement s'assurer de la santé du malade, mais aussi de coordonner les services sociaux et d'urgence, d'améliorer la qualité de la vie, de soutenir la famille et d'anticiper les problèmes des descendants. Du même coup, le médecin doit considérer le bien-être de la communauté au sein de laquelle le patient schizophrénique vit.

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This article is based on observations made during the first 3 years (1975–78) of a continuing study of schizophrenic outpatients at the Clarke Institute of Psychiatry in Toronto. The study is designed to discover optimal methods of treating schizophrenia.

Persons with schizophrenia, just like persons with leprosy, used to be hidden away in institutions, with little access to the medical attention of practitioners in the community. Because of limited access, little expertise was developed in the art of providing medical service to this large segment of the population. In the last 20 years, with treatment available for the control of flagrant symptoms, with the decrease in the number of institutional beds and with a more tolerant community attitude towards mental illness, schizophrenic patients have become part of every general practice. These patients may need to return periodically to a psychiatric facility, but they spend most of their lives in the community and make use of community medical services.

Characteristics of the patient in the community

Because symptoms and signs are now modified by neuroleptic drugs, schizophrenic patients in the community can be better defined by the consequences of their illness than by the original symptoms of schizophrenia. The illness usually begins in late adolescence; therefore, schizophrenic patients are unlikely to have completed their schooling, are interpersonally unpractised, have few firmly established links in the community and are usually vocationally untrained. Their life has been interrupted by several stays of months at a time in psychiatric wards. They are usually unemployed; this is true for 60% of the 135 patients attending the Clarke Institute's active treatment clinic for schizophrenia. As a consequence of unemployment and indigence their nutritional status is poor[1] and their residential conditions poorer still.[2-5] Of the patients attending the clinic 43% live alone.

Although social isolation is characteristic of schizophrenic patients in the community, there are differences between the men and the women. The women are more easily accepted by their families and, if single, more often live with their parents. Of our clinic patients 48% of the single men live with their parents, compared with 68% of the single women. More of the women are married (31% v. 18%). It seems as if the lack of social initiative that is a symptom of schizophrenia interferes with the men's

marriage prospects more than it does the women's, at least in our culture. At a European outpatient clinic for persons with schizophrenia 67.6% of the women were or had been married (36.0% married, 20.2% divorced, 11.4% widowed), compared with 28.9% of the men (20.2% married, 6.7% divorced, 2.0% widowed).[6] Hence, for men and for women the sequelae of schizophrenia are somewhat different. The men suffer most from the tragic consequences of loneliness, idleness and alienation. For those living at home, mostly the women, there are the problems of living with others, a task that entails numerous difficulties for the person with schizophrenia.[7,8]

An important characteristic of the person with schizophrenia in the community is that he or she likely takes neuroleptic medication, as is the case with 95% of the Clarke Institute clinic population and almost 100% of the populations of other outpatient clinics for schizophrenia.[9] Neuroleptics, while controlling hallucinations and blocking the tendency to delusion formation, possess a number of unfortunate side effects: they heighten the tendency to apathy and social withdrawal,[10] reduce the motivation to exert effort, reduce libido, produce a number of sensations that are unpleasant and sometimes frightening (light-headedness from orthostatic hypotension; tremulousness, restlessness and muscle stiffness from pseudoparkinsonism; blurred vision, nasal congestion, bladder and gastrointestinal disturbances from interference with parasympathetic functioning; and sunburn from skin photosensitivity, to list only the most common) and cause, after several years of treatment, chronic motor dysfunctions (e.g., tardive dyskinesia) that are difficult and sometimes impossible to reverse.[11,12] While most patients suffer some unwanted effects,[9,13] many do not complain about them because their somatic discomfort serves as a guarantee that the drug is working and that another terrifying psychotic experience will not supervene, or because it serves as a reason to postpone anxiety-inducing situations, such as returning to school, seeking employment or making friends.

Aims of the physician

The physician's aim in caring for the person with schizophrenia in the community is to control the symptoms of the illness while minimizing the deleterious effects of the medication. This is difficult. In addition, the physician must prevent the risk of suicide and paranoid crisis, avert rehospitalization if possible, discourage the indiscriminate use by the patient of emergency medical and social services, look after the patient's general health, attempt to improve the quality of his or her life, give the family emotional support and pay careful attention to the patient's offspring. The physician must also consider the welfare of the community. The patient must be prevented from harming others and health care costs must be kept manageable.

Maintenance of treatment

Perhaps the most important factor in the accomplishment of these aims is ensuring that the schizophrenic patient stay in treatment. By virtue of social withdrawal, paranoid feelings, denial of illness, discomfort from side effects of the drugs or misunderstanding of the illness, patients characteristically leave treatment. They do not keep appointments, tend to show up during a crisis, if at all, alienate their caregivers by being distinctly unappreciative of services rendered, move a great deal (often out of town) and become simultaneously embroiled with several caregiving agencies. Relatives frequently identify with the patient's misperception of the doctor as wicked or uncaring and heap blame for failure to improve on the doctor. Doctors, of course, fall into the same trap. They take at face value the patient's description of relatives as hostile or detached and do not attempt to include families in planning for the patient. As a result, the common experience is that schizophrenic patients do not stay in treatment.[14,15]

Making sure the patient returns rests on the following principles:

- Persons involved with the patient need to be aides rather than adversaries, whether relatives, landlords, friends, employers, teachers, welfare workers or probation officers. Contact is best established with these people at the onset of treatment, not during a crisis.
- The missing of appointments cannot be neglected. Patients may claim to have forgotten their appointments, but visits with a doctor assume even larger significance for schizophrenic patients (because of their relatively empty lives) than for most other people. A missed appointment has to be interpreted as a message of dissatisfaction with treatment, resurgence of symptoms (so that the patient believes it is dangerous to leave the house) or guilt at not having followed instructions and embarrassment at the thought of having to admit it. Whatever the cause, a missed appointment must be followed up by a phone call or a home visit if the patient is to stay in treatment.
- It is perhaps paradoxic that many schizophrenic patients with, it would seem, much time on their hands are jealous of their time, exquisitely sensitive to being kept waiting and frequently insistent on coming for appointments when they want to come and not when they are told to come.[16] What seems to work is an hour-long group meeting, held at the same time every week, to which patients can come as frequently as they wish. They can come late without penalty and leave early if they wish. This system has been highly successful at the Clarke Institute clinic and elsewhere.[17,18] It allows flexibility for patients and efficient use of medical time. There is time to get prescriptions written and to arrange individual appointments if necessary. The doctor has a chance to observe the patient interacting not only with authority but also with his or her peers. There is a forum for the discussion of side effects of drugs and of symptoms. There is a chance for patients to get to know each other, derive comfort from the similarity of their experiences, reassure and motivate each other, and learn

from each other. These are side benefits. The main aim of the weekly "drop-in" meeting is the flexibility, the element of patient choice and the very important fact that patients are not kept waiting. The group meets on time, even if the doctor is late. At the Clarke Institute clinic, meetings such as these have been fully attended, whereas more formal group sessions that patients were expected to attend regularly and on time never proved successful. The success of the group meetings depends on their constancy and continuity. A doctor in practice alone may find it difficult to provide coverage for the times he or she is unavoidably away.

- Psychotherapy or counselling by the doctor is often seen as providing schizophrenic patients with what they badly need: advice on structuring their lives, budgeting, making decisions, taking medication, avoiding stress and developing interpersonal skills. More important than providing for needs, if one wants to keep the patient in treatment, is providing for wants. Without continuation of treatment, needs are not met anyway. What schizophrenic patients want is to be treated with respect, to be given time and attention. The thrust of the doctor's words in psychotherapy must be to build self-esteem, to make the patient feel welcome, to make him or her feel better for having come to the doctor. Otherwise no amount of psychologic understanding or sound advice matters. The patient will not be back to hear it.

- Accessibility is the other important issue in keeping patients in treatment. Schizophrenic patients may have crises at any time. They often do not have telephones but may walk over when they feel they need to see the doctor. Finding the doctor away or occupied, with no provision made for someone else to look after the problem, will result in the patient's not returning. Since doctors cannot always be available, an invaluable asset is a kind, unhurried receptionist who will listen to the patient. Listening is often all that is required. Patients must always know how to reach the doctor or his or her standin at night or on weekends. Being associated with a hospital where there is a 24-hour drop-in service is a great advantage.

Symptoms v. side effects

Establishing the best maintenance regimen

How does one determine what dose of neuroleptic drugs will minimize both symptoms and side effects? There is no simple answer, especially since schizophrenic patients are notorious "noncompliers" when it comes to taking medicines, so that one never knows exactly how much of what one prescribes is being taken.[19,20] In addition, there is the difficulty common to most schizophrenic patients of inertia in the taking of drugs. Once a routine of medication has been established it is very difficult to persuade the patient to adjust the dose or the timing of administration. Since there are often many target symptoms (ideas of reference, lability of mood, social withdrawal, cognitive dysfunction and other problems, all of which may be present at the same time) how does one decide which symptoms to treat with the neuroleptic and which to leave alone? Since symptoms are not always present, how does one justify maintenance medication? When do side effects become more troublesome than symptoms?

What follows is the current approach of the Clarke Institute clinic.

To prevent acute psychotic relapse one must keep the patient taking a maintenance dose of medication.[21-25] This dose can be very low and still prevent relapse. It should be low enough that medication to counteract side effects (i.e., an anticholinergic) is not required and yet the patient experiences no side effects. For most patients this dose need be only 100 to 200 mg of chlorpromazine equivalent per day.[26]

In most patients a low dose such as this will not control episodically recurring symptoms. The patient must therefore be instructed to recognize the prodromal signs or symptoms (e.g., the "funny" feeling before hallucinations appear) and share with the doctor the timing (lag time and duration) of these symptoms so that they can together work out a way of administering neuroleptics in temporarily higher doses to forestall the appearance of frank psychotic symptoms.

In many cases this kind of cooperative arrangement does not work out. Sometimes patients need to be schooled to assume responsibility for the care of their illness and the prevention of symptoms. This schooling takes time. Often even the most assiduous of schooling fails.

If it is impossible to work out with the patient a regimen of a low maintenance dose and higher doses when needed, the next best approach is to attempt to control with the maintenance dose the symptoms about which the patient most complains. In other words, one raises the maintenance dose to a level that controls the symptoms that are intolerable to the patient — for example, a fear of strangers, uncontrollable rages or unpleasant ruminations. One leaves alone other symptoms, even obviously serious ones such as delusions and hallucinations, if they are acceptable to the patient. The purpose of limiting target symptoms to as few as possible is to keep the dose of neuroleptic as low as possible. Even trying to control only the symptoms that are intolerable to the patient makes it impossible, usually, to keep the dose low enough to prevent the appearance of side effects. One then has to discuss with the patient the pros and cons of using additional drugs to combat side effects. Usually the patient will choose to take an extra drug (an anticholinergic). If so, the physician should periodically (every few months) attempt to lower its dose and must ultimately discontinue the drug. In most patients side effects diminish with time and the anticholinergic becomes no longer required.[27-29] The concomitant use of an anticholinergic over the long term appears to increase the risk of the eventual development of tardive dyskinesia,[11,30,31] and this must always be kept in mind.

One always has to weigh risks against benefits. If increasing the neuroleptic dose sufficiently high to

combat a fear of strangers allows the patient to seek employment and to become self-sufficient and thereby self-confident, side effects are a relatively small price to pay. If, however, the dose is raised and the fear of strangers is overcome but the patient, for other reasons, does not return to work, side effects may be too costly. This sort of weighing necessitates constant vigilance and very frequent contact, with the understanding between patient and doctor and between relatives and doctor that the neuroleptic dose will be constantly shifting. This is often not easy to convey, especially since it has not been standard practice. Because of the myriad side effects and the constant risk of relapse, physicians have, in the past, been reluctant to tamper with the neuroleptic dose prescribed in the hospital during the patient's last admission. For most patients this dose is too high for the demands of their life in the community, though for some it may be too low. In any case, it needs to be constantly reevaluated.

In summary, maintenance neuroleptic medication is needed to prevent relapse. In the absence of troublesome symptoms the dose need be very low. Symptoms can be treated as necessary in cooperation with the patient. If this is impossible the maintenance dose must be increased to control the symptoms that are intolerable to the patient. Anticholinergics may be needed temporarily if this dose produces uncomfortable side effects.[32] Not all symptoms need to be controlled, only those that substantially interfere with important aspects of the patient's life.

Depot neuroleptics

Injectible depot neuroleptics have been found to be invaluable for patients who cannot remember to or deliberately choose not to take their oral medication. They are also far less costly than tablets. The injections are given from once a week to once a month and have gained acceptance by patients and doctors. The difficulty is that, unless the dose is very low, depot neuroleptics produce enough side effects to necessitate the concomitant use of anticholinergics. At the Clarke Institute clinic 32% of the patients are receiving depot medication and 52% of the clinic population are taking anticholinergic drugs because of side effects. At another Canadian clinic for schizophrenia 38 (79%) of 48 patients receiving depot medication require anticholinergic drugs.[33] At a clinic in the United States where written consent is required for the administration of injectible drugs, only 28 (5%) of 575 patients were reported to be receiving depot medication and only 22% of the total clinic population were taking anticholinergics.[9] Another difficulty with injectibles is that one cannot easily adjust the dose to control symptoms except by using a very low dose of the injectible drug as maintenance medication and adding tablets when symptoms recur. While injectibles get around the problem of unknown compliance (the physician knows that the patient is receiving the medication) they may be creating more problems than they are curing. More than their orally administered counterparts, the injectibles have been implicated in the development of postpsychotic depression[34] and in the accelerated development of tardive dyskinesia.[33,35] At this stage in our knowledge it is probably wiser to restrict the use of depot drugs to patients who have proven themselves to be dangerously unreliable in the taking of oral medication. Even then, a periodic trial of orally administered drugs should be undertaken.

Drug holidays

Because of the problem of side effects "drug holidays" have been advocated. It is best if the patient is given an extended drug-free period every several months, during which he or she is extra carefully monitored. The period may vary in length, depending on the patient and the purpose of the holiday. The drug-free period shows the patient that he or she can live for a time without medication and without relapse. Sometimes, because of the removal of side effects, the patient may feel better than usual during this period. If long enough, the drug holiday will demonstrate to the patient and to the family that, in time, symptoms begin to return. This is a lesson that patients and families need to learn many times. Patients need to familiarize themselves with their own idiosyncratic prodromal signs[9] and with their own characteristic rhythm of waxing and waning symptoms. For instance, in one patient headaches may be a warning sign. In another insomnia, perceptual changes or a reluctance to leave the house may be warning signs.

A 6-week drug holiday is usually safe to start with. In that time many patients will begin to re-experience some unpleasant symptoms, but only 10% will suffer, if left unattended, serious relapse.[24] Patients on a drug holiday should be seen at least weekly. The patient and the family must know how to contact the doctor immediately in case of need, and all parties involved must realize that drug therapy may have to be restarted before the 6 weeks are up.

Once an individual pattern is established, both patient and doctor will know approximately how long a drug holiday is safe for the particular patient. For some patients the drug holiday may eventually become permanent;[36] these people cannot be picked out in advance and are not necessarily the patients with the fewest symptoms. The fact that a patient exhibits relatively few symptoms, or even no symptoms, while taking neuroleptics says nothing about his or her risk of relapse without drug therapy.

The other uses of drug holidays are in the detection and prevention of tardive dyskinesia. The frequency of tardive dyskinesia is correlated to the total duration of neuroleptic therapy, so the shortening of that period by regular drug holidays is likely to cut down on the frequency of this syndrome.[37,38] As well, tardive dyskinesia, being a hypersensitivity syndrome (the hypersensitivity is to endogenous dopamine at basal ganglia receptors[39]), is masked by the dopamine-blocking action of neuroleptics and comes to the fore when the neuroleptic dose is reduced or the drug is discontinued temporarily. Thus, drug holidays facilitate the early detection

of tardive dyskinesia, a syndrome that is reversible when detected early.[40] Once a person is noted to have tardive dyskinesia one must be careful to treat him or her with doses of neuroleptics that are as low as possible and to ensure that drug-free periods are as frequent and as long as possible.

Prevention of sequelae of schizophrenia

Treating symptoms and minimizing side effects is just one part of the task of caring for schizophrenic patients. As in any other lifelong illness, prevention of naturally occurring sequelae is another important part of comprehensive care.

Suicide

One of the tragic sequelae of schizophrenia is suicide.[41] The Clarke Institute clinic has had a suicide rate of approximately 1% every 6 months. This rate is similar to that reported elsewhere.[42] Whereas suicide in persons with schizophrenia is frequently impulsive and therefore unpredictable and unpreventable, several points should be kept in mind. All of the Clarke Institute clinic patients who committed suicide had been receiving medication and were therefore relatively nonpsychotic. In other words, in no instance was the suicide a response to an active psychotic delusion. In every case the patient was realistically depressed about his (they have all been men) life. All had had several bouts of acute psychosis but were not yet resigned to the idea of having a chronic illness and could not accept the continuing disabilities of their nonpsychotic state. They had lost what used to keep them going — the optimism of youth and their early ability to deny the implications of their illness. This phase of the schizophrenic illness is particularly depressing. In all instances the patient had either lived with or been closely allied to a family to whom he felt himself to be a disappointment. Patients who do not feel the burden of others' expectations seem to be less at risk for depression.

Depression in schizophrenia is well known.[43,44] Antidepressants can be effective but they can also induce psychosis and can increase the anticholinergic effects of the neuroleptic and the anticholinergic drug. For this reason they are not often advocated in the treatment of schizophrenia.[45] Sometimes depression can be relieved by alleviating the akinetic effect of neuroleptics.[10] Personal contact and accessibility of the therapist in times of crisis seem to be the most important ingredients in the prevention of suicide. None of the Clarke Institute clinic patients attempted to take an overdose of their drugs. Instead they jumped out of windows or shot themselves, acts of impulsive despair. Anticipating the crisis by assuring patients that a phone call, whether during the day or at night, will be answered by the doctor or his or her replacement as quickly as possible is probably the best hedge against suicidal despair.

Psychosocial crisis

The doctor must also try to prevent the sequelae of psychosocial crisis: eviction, abandonment by relatives, rejection by a friend, loss of a job. These tend to be frequent in the lives of schizophrenic individuals and disruptive of mental and emotional equilibrium. A good working relationship with hostels and welfare workers allows speedy and effective intervention by the doctor. At the Clarke Institute clinic such services as a volunteer with a car to help transport furniture or the provision of subway tokens to get the patient to the welfare office when the cheque is late have done more to avert psychosocial disruption than well intentioned but ineffective counselling.

Rehospitalization

It is also the doctor's task to prevent rehospitalization. Despite careful follow-up of the Clarke Institute clinic patients there were 40 rehospitalizations during the year 1976–77; 27 of the 135 patients were rehospitalized at least once. The readmissions to hospital were usually due to a resurgence of psychotic symptoms following the discontinuation of neuroleptic medication. Other causes were depression and threat of suicide, severe psychosocial stress, severe side effects of medication and problems in the therapist-patient relationship. Schizophrenic patients are often admitted to hospital when their therapist is away on vacation or when there is a change of therapist.[46] At the Clarke Institute clinic these problems are managed by assigning two therapists per patient.[47] This method, which has been reported elsewhere,[17] allows continuity of care but does not, as the rehospitalization statistics show, prevent readmissions.

Patient and family may not always see rehospitalization in a negative light. It allows a respite for the patient and for the family and may contribute to changes in diagnosis or in treatment focus that are beneficial to the patient. As long as they are kept short, rehospitalizations do not necessarily interfere with the patient's employment, education or ongoing relationships. It is outside the primary physician's power to ensure that his or her patient's hospitalizations, when they are necessary, are kept short, but inquiry can be made into the policies of the psychiatric ward to which the patient is entrusted. Many facilities have short-stay policies or day therapy options that are helpful to the schizophrenic patient.[48,49]

When hospitalizations cannot be averted, it is preferable that they be not only short but also voluntary. Involuntary commitment to a psychiatric facility is a difficult process for all parties involved: patient, family, doctor and admitting psychiatrist. Once the doctor takes part in an involuntary commitment it may be difficult to re-establish the relationship with the patient.

There does not seem to be any certain way to prevent involuntary hospitalizations. In the year 1976–77, 5 of the 40 Clarke Institute clinic patients admitted to hospital needed involuntary commitment. Cooperation was ensured in the others by recommending hospitalization early in the decompensation process, before paranoid delusions and inability to trust others set in. Assuring the patient of a short stay is helpful. It also helps to discuss periodically with all

schizophrenic patients the statistical probability of rehospitalization and to determine with them in advance where hospitalization should take place if it becomes necessary. Frequently the objections are not directed at hospitalization per se, but only against a particular ward, a particular nurse or doctor, or a particular treatment procedure.

It is difficult to tell people what to expect in hospital if one is not acquainted with what goes on in a particular psychiatric facility. Familiarizing oneself with the psychiatric scene makes liaison easier and makes consent to treatment easier to obtain.

Use of other facilities

Because of helplessness secondary to the disease, schizophrenic patients often depend on helping agencies and often become involved with many. It is not unusual for patients to be simultaneously connected to a variety of rehabilitation programs, day care centres, vocational services, volunteer agencies etc. All these agencies function independently and, unless coordinated, may be working at cross-purposes. Patients are bewildered, costs augment and the various helpers waste time duplicating each other's work and vainly attempting to communicate with each other. When many agencies are involved, someone needs to coordinate the efforts. If the doctor is unwilling to act as coordinator it is better to reduce the number of agencies involved.

Emergency departments are frequently used by some schizophrenic patients as primary care facilities. Of the Clarke Institute clinic patients 13% accounted for all the emergency room use. Those 13% did not overlap with the 20% suffering crises that required readmission. None of the frequent users of the emergency room were rehospitalized. Rather, they were people who lived near the hospital and went to the emergency room because of minor colds, fevers, upset stomachs, intoxication, insomnia, fights with relatives and loneliness. Often their arrival at the emergency room followed an altercation with the therapist. Whereas the availability of an emergency room is important for schizophrenic patients, use of it may be detrimental if emergency room personnel begin to identify the patient as a habitual user "who is not really ill". They then treat the patient badly and remove the availability of a necessary refuge in times of crisis. The ease with which the doctor can be reached by telephone for critical advice or reassurance will determine the patient's need to visit the emergency department.

General health

It is probably unnecessary to remind physicians that schizophrenic patients can, like everyone else, suffer from other medical problems that need care. Because of poor nutrition and poor hygiene the schizophrenic patient is especially vulnerable to illness. At the Clarke Institute clinic the most common medical problems are obesity, alcoholism and hypertension. Vitamin supplements are frequently required. Constipation is a common problem and is secondary to neuroleptic therapy and to a predominantly carbohydrate diet. Dental health is poor. Possible eye complications of long-term neuroleptic therapy require regular ophthalmologic consultation.[50]

Quality of life

The most striking features of the everyday life of the schizophrenic person is its monotony and lack of variation, and the absence of any apparent joy in living. This is evident in miniature in the eating patterns of the clinic population. In a comparison with control subjects the clinic patients were found to eat the same foods every day, for every meal. There was no variety and no seeming satisfaction. There was no attempt to prepare meals; the common pattern was to snack throughout the day.[1]

This pattern permeates the schizophrenic person's life. There are few relationships, and those that exist are routine and unsatisfying. There is no recreational activity except for habits such as weekly Bingo games or a daily walk around the park. Life is mostly sedentary. Creative outlets are few and solitary. Education is not pursued. Employment, when it exists, is dull and unvaried. When there is no employment, leisure time hangs heavy and dull. Although it is not a traditional concern of the physician to attempt to improve the patient's life, in the case of the schizophrenic individual listlessness seems to be so much a part of the illness that the physician may well assume responsibility. Enquiry into how the patient spends his or her day quickly reveals the emptiness of the patient's life. Admonishment and encouragement to be more active do not change much. At the Clarke Institute clinic the only method that has worked in changing lifestyle patterns has been to introduce a nonthreatening person (a volunteer from the institute's volunteer assistance program, a community occupational therapy association worker or a public health nurse) to accompany the patient to new activities.[51]

Responsibility to the patient's family

Much has been written in the psychiatric literature on the contribution of the family to the patient's illness in terms of cause[52-54] or recurrence of symptoms.[7,8] Little has been written about the burden a schizophrenic person imposes on his or her family.[55] The presence of a schizophrenic person in a family carries the same burden as the presence of any other chronically disabled individual, with the added problems of unpredictability, denial of illness, noncompliance with treatment by the patient and a general attitude of exclusion by the medical profession. The schizophrenic patient frequently insists that the family not be contacted and not be part of treatment planning. The doctor, having promised confidentiality, can then not answer questions when the family calls and they quickly get the message that they are not wanted. Worse, they usually feel that they are being held responsible for the illness.

At the Clarke Institute clinic, after attempts both to include and to exclude families, the smoothest course has turned out to be stating clearly to the patient at the inception of treat-

ment that the family will be seen, will be kept informed and will be consulted. Specific information, when necessary, is kept confidential from the relatives.

Family members derive much support from each other. The questions they have are often best answered by people who have gone through the same experience rather than by medical personnel, whose perspective is always different. The literature on group support for families is extensive.[56] The Clarke Institute clinic runs a weekly group meeting for patients' relatives. There is also a weekly group meeting for patients who are themselves parents, designed to help with parenting problems. The children of schizophrenic individuals are at high risk for schizophrenia,[57] both genetically and secondarily because of hospitalization-induced discontinuities in parental care. The parent's lack of imagination and motivation also creates problems in child-rearing. The parenting group provides surrogate parenting in case of crisis or rehospitalization (usually through the Children's Aid Society, relatives or close friends). It also provides ideas and mutual support to help combat parental deficiencies in creative and flexible child-rearing.

Responsibility to the community

Finally, the physician has a responsibility to the community to ensure that health care costs for this large segment of the population are kept manageable,[58,59] and that patients do not present a threat, real or imagined, to their neighbours.

Costs to the community are kept down if the rehospitalization rate is kept low, each stay in hospital is kept short, and the use of helping agencies and emergency facilities is kept to a minimum. Enabling patients to work saves money, as does freeing relatives to work.

Danger to the community can be obviated by prompt involuntary commitment if it becomes necessary. "Threat" to the community in terms of the patients' looking strange, muttering to themselves, staring oddly or acting unpredictably without being in any way dangerous is another matter. Strange types of behaviour do frighten people who cannot understand them, and it is often for this reason that doctors do not like to have too many schizophrenic patients in their practice. They may worry other patients in the waiting room just as they worry neighbours. Public education helps, and the present climate is much more understanding of idiosyncracies in behaviour. The frightened responses of others elicit reactions from the patients — usually increasing fright and hostility, paranoia, withdrawal and increasingly odd behaviour. For this reason it is helpful to see schizophrenic patients on days when the office is less crowded. Advising people on where to live (e.g., group homes or sheltered settings) to be less offended by the reactions of others, and to be less offensive, becomes part of the physician's responsibility.

Some schizophrenic patients are best treated in specialized clinics and some are best treated by private practitioners.[60] A large number of patients will always elect to be treated by their family doctor. If expectations are unrealistic, the care of the schizophrenic individual may be frustrating and burdensome. On the other hand, if goals are appropriate to what is known about the natural history of the illness, treatment becomes challenging and rewarding.

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